

Montana Children's Health Insurance Plan (CHIP)
Dental Provider Enrollment Application – Provider Type 66
For Current Medicaid Dental Providers

For Fiscal Agent Use Only:

ACS Assigned Provider Number

Approval Date

Business or provider name:

Business telephone and fax number:

(____) _____ - _____ (Telephone)

(____) _____ - _____ (Fax)

Physical address:

County:

Mailing address:

Send completed enrollment form to:

ACS
Provider Enrollment Unit
PO Box 4936
Helena MT 59604

- ☐ **I am a Montana Medicaid dental provider – Medicaid dental provider # _____.**
Please refer to my Medicaid provider application for information regarding my professional license, specialty, certification, ownership information, W-9, and DEA number. I hereby certify that the information provided on the Medicaid application remains true, complete, and accurate. (Please note: If any information on the Medicaid application has changed, please make a copy of your Medicaid application and sign and date any changes.)

Provider Agreement and Signature

The provider certifies that the information provided on this enrollment form is to the best of the provider's knowledge, true, accurate, and complete, and that the provider has read this entire form before signing. In consideration of CHIP payments made for appropriate services rendered to children enrolled in CHIP, and in accordance with any restrictions noted herein, the provider agrees to the following:

The provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to Montana CHIP, including but not limited to Title XXI of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM), written Department of Public Health and Human Services (Department) policies, and the terms of this document.

The provider certifies that the care, services and supplies for which the provider bills CHIP have been previously furnished, the amounts listed will be due and, except as noted, no part thereof will have been paid. Payment for services made in accordance with established rates, schedules or methodologies will be accepted as payment in full.

The provider assures the Department that the provider is an independent contractor providing services for the Department and that neither the provider nor any of the provider's employees are employees of the Department under this enrollment form or any subsequent amendment. The provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts which may be legally required with respect to the provider and the employment of all persons providing services under this enrollment form.

The provider agrees to comply with those federal requirements and assurances for recipients of federal grants provided in OMB Standard Form 424B (7/97) which are applicable to the provider. The provider is responsible for determining which

requirements and assurances are applicable to the provider. Copies of the form are available from the Department. The provider shall provide for the compliance of any subcontractors with applicable federal requirements and assurances. The provider, as provided by 31 U.S.C. 1352 and 45 CFR 93.100 et seq., shall not pay federally appropriated funds to any person for influencing or attempting to influence an officer or employee of the U.S. Congress, in connection with the awarding of any federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement.

The provider agrees to comply with the applicable provisions of the Civil Rights Act of 1964 (42 U.S.C. 200d, et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990 (42 U.S.C. 12010, et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.794).

The provider may not, on the grounds of race, color, national origin, creed, sex, religion, political ideas, marital status, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under CHIP or any activity connected with the provision of CHIP services.

All hiring done in connection with the provision of CHIP services must be on the basis of merit qualifications genuinely related to competent performance of the particular occupational task. The provider, in accordance with federal Executive Orders 11246 and 11375 and 41 CFR Part 60, must provide for equal employment opportunities in its employment practices. The provider shall use hiring processes that foster the employment and advancement of qualified persons with disabilities.

The provider further agrees to, in accordance with relevant laws, regulations, and policies, including the 1996 Department Policy of Confidentiality of Client Information, protect the confidentiality of any material and information concerning an applicant for or recipient of CHIP services.

The provider agrees to make and maintain records, as required by applicable laws, regulations, rules, and policies, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. The provider agrees to furnish on request to the Department, the United State Department of Health and Human Services, and any other authorized governmental agency or agent thereof any records maintained under applicable laws, regulations, rules and policies.

The provider agrees to comply with the disclosure requirements specified in 42 CFR, part 455, subpart B, including but not limited to disclosure of information regarding ownership and control, business transactions and persons convicted of crimes. Upon request, the provider agrees to provide to the Department and the U.S. Department of Health and Human Services the information required in 42 U.S.C.A. §1396b(s) pertaining to limitations on certain physician referrals.

The provider agrees to repay to the Department (1) the amount of any payment under the CHIP program to which the provider was not entitled, regardless of whether the incorrect payment was the result of Department or provider error or other cause, and (2) the portion of any interim rate payment that exceeds the rate determined retrospectively by the Department for the rate period.

The Provider agrees to notify ACS at the address stated above within 30 days of a change in any of the information in this enrollment form.

The Provider acknowledges that this enrollment is effective only for the category of services stated above and that a separate provider enrollment form must be submitted for each additional category of services (i.e., dental, eyeglasses, etc.) for which CHIP reimbursement is sought. Dental services that are covered as a medical service by the CHIP insurance carrier must meet the requirements of the appropriate CHIP insurance carrier. Claims for dental services must be submitted to the insurer, not to the Department.

The provider understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Individual Practitioner Name (Printed)	
Individual Practitioner Signature	Date
Or for facilities and non-practitioner organizations:	
Authorized Representative Name (Printed)	Title/Position
Address	Telephone Number
Authorized Representative Signature	Date